**MEETING MINUTES FOR THE**
**GOVERNOR'S COUNCIL ON BEHAVIORAL HEALTH**
**THURSDAY, JUNE 9, 2016**

**Members present:** Ann Mulready, Brian Sullivan, Sarah Dinklage, Ruth Fedder,

**Statutory members present:**

**Ex-officio members present:** Denise Achin, DOE; Colleen Polselli, DOH;; Alice Woods, DOE; Ann Detrick, Michelle Brophy, Linda Barovier, BHDDH;

**Guests:** Celia Robinson, Anatoly Burke, Christian Delacruz (Parents Support Network); Jim McNulty, (Mental Health Consumer Advocates); Lisa Tomaso (Providence Center); Sam Smith (Health Foundations Youth Coordinator); Amy, Susan Lindbergh, Ranny Dougherty (DCYF); David (NAMI RI); Jim Peacy (RI Kids Count)

**Staff:** Jim Dealy



Ann Mulready, chairing the meeting in Rich Leclerc's absence, asked the group to review the prior month's minutes. A motion was made to accept. Ruth Feder requested that her statement regarding the Olmstead decision be amended to include the phrase, "if a person is living in an institution and would be more appropriately placed in the community." Jeff Hill also requested a change. Minutes accepted with amendments.

**<u>Olmstead Plan</u> (Ruth Feder):**

Ruth explained the Olmstead decision, which was a Supreme Court ruling that said that outcome was that individuals have the right to be in the most appropriate integrated setting possible and that keeping someone in an institution unnecessarily is discriminatory and violates the Americans with Disabilities Act. The Court ruled that individuals have the right to be in the most appropriate integrated setting. Furthermore, it recommended that each state create its own Olmstead Plans. There have been several attempts to create a RI Olmstead Plan, but none have succeeded. Ruth noted that, per the Truven Report, Rhode Island spends a disproportionate amount of its budget on high end residential, and hospital care, rather than on less restrictive care that is more appropriate. She suggested that RI create an Olmstead Plan. She is bringing this to the Governor's Council as it is the best group to take the next step, potentially asking the Governor to create a task force or commission to design, create and implement the plan.

Michelle Brophy said she would support such a plan. Several years ago BHDDH applied to SAMSHA for an Olmstead planning grant. We worked together with a number of state agencies for four months and came up with an outline of a plan, which required an interagency Olmstead Council. Due to opposition to such a council, the plan was voted down.

Jim McNulty commented on the history of the plan in RI and noted that the Governor's Council could be useful in serving as a depository of history of these things and making sure that plans such as Olmstead have action taken to move them forward.

Lengthy discussion and questions continued on the topic.

Motion made that the Governor's Council on BH create an ad hoc committee to accumulate data and other support for the purposes of informing the Governor of the need of an Olmstead Plan and to request that the Governor issue an executive order creating an Olmstead Plan Commission. Motion was seconded. Motion passed.

Attendees had opportunity to sign up if interested in serving on committee.

**SIM Plan (Ann Detrick):** Ann Detrick is BHDDH's representative on the SIM grant project, and also works on the Certified Community Behavioral Health Clinic (CCBHC) grant project. SIM is a four year, $20 million federal grant that Rhode Island received last year. Its focus is on transforming health care to better meet the needs of people in the state. It focuses on: patient centered care, including patient engagement; collecting and sharing healthcare data across organizations; increasing value in our health care system, with a lot of focus on value based payment. EOHHS is the overseer of the grant and the Office of the Health Insurance Commissioner, the Department of Health and BHDDH participate. DCYF has also participated actively The SIM Steering Committee meets on the first Thursday of the month at the Hewlett Packard Building. It is an open meeting. If anyone is interested in attending, please follow up with Jim.

She explained a handout which is a wheel representing everything supported by the grant. It is a graphic to communicate more clearly about what is taking place. She walked through the BH initiatives being funded in SIM. Some have not begun yet. Lot of focus on the integration of BH and physical health. There is a push to improve the outcome for individuals with severe mental illness. She referred to a study done several years ago which showed that these individuals generally dies 20 years earlier than the general population due to impacts of psychiatric medication and their not having access to very good health care.

Ann introduced a number of aspects of the SIM effort:

She spoke about the **Child Psychiatric Access Project**. This will replicate a program which began in Massachusetts. It addresses the need for pediatricians to have psychiatric expertise available to them and the great shortage of child psychiatrists who take public insurance. This project will take a skilled child psychiatrist to provide support to pediatricians in the community. It is a consultation service with an expert child psychiatrist. The pediatrician's office is generally the place where some kind of emerging mental health condition might present. A call is received from a pediatrician and within a half hour the psychiatrist is obliged to call the pediatrician and have a phone consult about the concern pediatrician has about their patient. The main objective is to get pediatricians more comfortable with prescribing.

However, if a child is suffering from a severe disorder arrangements can be made for that child to get care from a child psychiatrist or child mental health service provider.

$602,000 has been allocated for this program across three years. An entity will be hired which will have a psychiatrist and licensed social workers or counselors and has the capacity to respond within 30 minutes.

There were questions asked and answered around trauma informed care, over-prescribing of medication and training pediatricians about the signs of behavioral illness.

Brenda Amodei, BHDDH, urged Ann to advocate for a person-centered practice model and an understanding of youth/young adult issues in the framing of the RFP. Ann said she would follow up.

Michelle Brophy spoke on the **SBIRT** (Screening, Brief Intervention, and Referral to Treatment) received by BHDDH and EOHHS. It is a five year grant for approximately $1.6 million dollars per year. SBIRT is a protocol for providers to screen individuals for substance use level and readiness to change substance abuse patterns and to provide referrals for treatment. It is coordinated with the SIM program, enhancing the ability of medical practices to address substance abuse issues. The project will hire health educators and health navigators to work in primary care offices or health centers to implement the screening. The navigators will move with the people who score high on the screening into the community. BHDDH has developed MOAs with all of its treatment providers so that treatment slots can be available within 48 hours of referrals from the SBIRT providers. The grant calls for services and systems change. The focus will be on working with the communities that have the highest level of need. The SIM grant's interagency council will work on the making the program sustainable, coming up with a payment method that allows practices to do the screening in an economically feasible way. The SIM project director will oversee the staff hired.

A member asked whether there could be SBIRT training for student assistance councilors in the state's high schools.

Ann said the reason SBIRT is centered around SIM is that it approximately $400,000 dollars over the life of the SIM grant was set aside to training the navigators and other staff who will be involved in the project. The goal is to have 250,000 people receive SBIRT screens screened over the grant's five years.

**Integrated Behavioral Program for PCPs** – There is an organization called the Care Transformation Collaborative (CTC) which has been working with primary care practices around the state to help them become more focused on their outcomes for consumers, ready for the new payment system we think we will coming at some point. The CTC received funding from the RI Foundation to help support 12 primary care practices to integrate behavioral health into their clinical work. The practices cover approximately 16,000 covered lives and all of them are in the process of adding behavioral health specialists. The SIM money is being used for some of the training being done and with evaluation of the project. The goal is to determine what SIM can learn from this initiative that can be carried through into other primary care practices throughout the state.

**Care Management Dashboard for CMHC** – A real time communication system will be developed and available to all of our CMHCs and their key staff. It will be an electronic dashboard which delivers real

time information to mental health centers when consumers go into the hospital or are discharged. Ann has asked the IT staff involved with this if there was a way to connect it to Corrections.

**Provider Coaching for Community Mental Health Centers** –This would be bringing primary care expertise into our community mental health centers.

Another piece of SIM is the creation of a **population health plan** for RI. There is a population health workgroup which is looking at how we think about population health at large; both behavioral health and physical health care. The plan is looking at tracking measures in areas of concern. At some point there may be a SIM "Road Show" where there may be meetings in local areas to share and plan and get input on it.

A Council member spoke of the need for more time at annual visits if pediatricians are expected to provide mental health assessment. There was discussion of the low reimbursement rates for private providers. Question asked regarding expanding the SIM BH Plan to OTPs and other providers.

**BHDDH** – Michelle Brophy said the CCBHC grant project will be sending out a needs assessment through a survey monkey. She asked everyone to take the time to complete the short survey, as it will help direct where we focus the CCBHC work being done. She asked the participants to forward the survey to community groups or stakeholders that they think would want to provide input.

BHDDH Redesign – The Division of Behavioral Health is going through a restructuring. The division will have five units: policy/planning; research, data evaluation and compliance; licensing; contract management; and program implementation and community engagement. All of the units will incorporate primary prevention and treatment for behavioral health preventive substance use disorders. The reorganization's goal is to better address the needs of the individuals and families who participate in the program that we provide. There are several objectives. One is to improve the integration of the division's functions. Another is to leverage federal funding by strengthening policy, data and fiscal units. A third is to increase resources and assist community partners in implementation of best practices or promising practices. Finally, it is intended to ensure that existing contracts, grants and programs are effective and meeting the needs of the individuals who are participating in them.

A key divisional role is to oversee the implementation of BH dollars that are administered through managed care organizations. We are working more closely with Medicaid in order to make sure that the funds that managed care organizations are using the best practices and moving forward with good treatment. Another key role is the administration of the Block Grant, including developing an active collaboration with the Governor's Council We have not had enough staff to do this as well as we want to. SAMHSA has said that other states use block grant dollars to have the staff to implement. This year, we have been able to take six percent of the substance abuse block grant and use those funds through resource development to bring in more policy and planning staff, fiscal staff and data staff. Through this small amount of money the division will be able to provide training and technical assistance to agencies who will use it on critical issues which will strengthen the agencies and the community. This will also help us to apply for more federal grants.

Former director, Montanaro had decided that she wanted state employees, rather than contract staff, to fill these new positions. Unfortunately, Jim Dealy will not be able to work as a state staff person and his last day will be August 31.

The redesign is taking longer that we had wanted but by doing this it puts us in a better position, both to maintain a level of Block Grant implementation that is acceptable to SAMHSA and to increase the level of discretionary grant programming. .

**Comments by Chair** – Ann thanked Jim, Maxine and Denise, who will be leaving, for their valuable service.

**Comments** – Jim Dealy noted that he needs to send out the last annual report and hoped that at the next meeting some time could be given to this.

Ann said a sign up sheet is being circulated on the ad hoc work group to talk about developing a proposal to the governor for an executive order for Olmstead.



**Adjourn -** The meeting was adjourned by vote of the members.

***Next Meeting:***

**Tuesday, July 12: 1:00 PM**

**Conference Room 126, Barry Hall,**

**14 Harrington Road, Cranston, RI 02920**

**Statutory and Public members, please let Jim Dealy know if you cannot attend**

**This meeting is open to the public.**

**If you plan to attend and you require special accommodations to ensure equal participation, please contact Jim Dealy at the Division of Behavioral Healthcare Services at 462-0118.**